STATE OF TENNESSEE

DEPARTMENT OF COMMERCE AND INSURANCE

TENNCARE DIVISION

AND

OFFICE OF THE COMPTROLLER OF THE TREASURY

DIVISION OF STATE AUDIT

CLAIMS PROCESSING AND FINANCIAL

EXAMINATION REPORT

OF

TENNESSEE BEHAVIORAL HEALTH, INC.

NASHVILLE, TENNESSEE

FOR THE PERIOD JULY 1, 1998 THROUGH JUNE 30, 2000

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DATE: October 26, 2001

SUBJECT: Claims Processing and Financial Examination Report of Tennessee Behavioral Health, Inc., for the period July 1, 1998 through June 30, 2000

A TennCare Partners Program examination of claims processing and a limited scope financial examination of Tennessee Behavioral Health, Inc., 222 Second Avenue North, Suite 220, Nashville, Tennessee, 37201, was completed February 21, 2001. The report of this examination is herein respectfully submitted.

I. FOREWORD

This report reflects the results of a TennCare Partners examination report "by test" of the claims processing system of Tennessee Behavioral Health, Inc. (TBH). The results of those tests are included herein.

Further, this report reflects the results of the limited scope review of financial statement account balances as reported by TBH.

II. PURPOSE AND SCOPE

A. Authority

The terms and conditions for authorizing the TennCare Partners Program, as well as the contracts between the State of Tennessee and the behavioral health organizations (BHOs), require that examinations of the BHOs be conducted.

This examination was conducted jointly by the TennCare Division of the Tennessee Department of Commerce and Insurance (TDCI) and the Office of the Comptroller of the Treasury, Division of State Audit (Comptroller) under the authorization of Section 3.12.10, 3.13.1, and 3.14.3 of the TennCare Partners contract between the State of Tennessee and the BHOs and Tennessee Code Annotated Sections, 56-51-132 and 56-32-215.

B. Areas Examined and Period Covered

The claims examination focused on the claims processing functions and performance of TBH. One hundred ten claims were selected for testing from claims processed by TBH from July 1, 1998 through June 30, 2000. The fieldwork was performed from November 2000 through February 21, 2001.

The financial review focused on the balance sheet and income statement as reported by TBH on its National Association of Insurance Commissioners (NAIC) Quarterly and Annual Statements for the periods ended July 1, 1998 through June 30, 2000.

C. Purpose and Objective

The purpose of the claims testing is to determine whether TBH processes claims in accordance with TennCare Partners contract and to determine whether TBH adjudicates such claims timely and accurately.

One objective of the examination is to select for testing, claims processed by TBH to determine if adjudication errors exist and to determine if TBH processed these claims in accordance with the terms of the TennCare Partners contract. These test results are not intended to be representative of the entire claims population of TBH for the aforementioned period.

The purpose of the financial testing is to determine the validity of TBH's assertions that it has complied with certain financial-related requirements of its contract with the state.

The objectives of the financial review are to determine if amounts reported on the NAIC Quarterly Statements are properly classified and if the amounts reported are properly supported with documentation.

III. PROFILE

A. Overview

The TennCare Partners Program, a managed care capitation program for mental health and substance abuse services, was initiated on July 1, 1996, and is designed to function in a manner similar to the TennCare Program. TennCare replaced the existing Medicaid Program on January 1, 1994, with a program of managed health care providing traditional medical services. Prior to July 1, 1996, mental health and substance abuse services were generally funded by grants or fee-for-service payments from the state. Although some grant payments, such as contracts with the Department of Children's Services, to the community mental health centers are unaffected by the TennCare Partners Program, funding for most of the services has shifted to the TennCare Partners Program. Each month, the state pays a capitation rate for each TennCare Partners Program participant to one of the two managed care organizations, referred to as behavioral health organizations (BHOs), that contract with the state to provide mental health and substance abuse services. The BHOs are Premier Behavioral Systems of Tennessee, LLC, and Tennessee Behavioral Health Inc. (TBH).

The assignment of TennCare Partners Program participants to the two BHOs is based upon the participants' enrollment in the TennCare managed care organizations. There were approximately 595,000 TBH participants as of June 30, 2000. During the examination period, the managed care organizations and their assigned participants to TBH were as follows:

- Tennessee Coordinated Care Network
- Volunteer State Health Plan, Inc.** (in East Tennessee* and Knox County)
- Preferred Health Partnership, Inc.

- Prudential Community Care (Ended 12/31/99 – members moved to Memphis Managed Care)
- Memphis Managed Care Corporation

*East Tennessee includes the following counties: Anderson, Blount, Campbell, Claiborne, Cocke, Grainger, Hamblen, Jefferson, Knox, Loudon, Monroe, Morgan, Roane, Scott, Sevier, and Union.

**Doing business as BlueCare.

The remaining managed care organizations' enrollments, approximately 722,000 participants, were assigned to Premier.

There are two categories of participants in the TennCare Partners Program: priority participants and basic participants. Priority participants include individuals diagnosed as severely and/or persistently mentally ill (SPMI) aged 18 years or older and individuals under the age of 18 diagnosed as having severe emotional disturbance (SED). TennCare Partners participants who are not priority participants are referred to as basic participants. Services covered for both the priority and basic participants include inpatient psychiatric hospitalization, outpatient mental health services, substance abuse treatment, psychiatric pharmacy and lab-related services, transportation to mental health and substance abuse services, and specialized crisis services. Additional services covered for the priority population includes mental health case management, 24-hour residential treatment, housing/residential care, specialized outpatient and symptom management, and psychiatric rehabilitation services.

An additional category of individuals for which mental health and substance abuse services are covered by the BHOs is judicials. These individuals are not considered enrollees or participants in the BHO plan but are entitled to coverage for services required by the statute or court order under which the individual was referred.

B. Responsibilities of Contracted Parties

The Tennessee Department of Mental Health and Developmental Disabilities [formerly Tennessee Department of Mental Health and Mental Retardation (TDMHMR)] is the state agency responsible for administration of the TennCare Partners Program. TDMHMR and the Bureau of TennCare are responsible for verifying the eligibility of participants and for assigning them to and disenrolling them from the TennCare Partners Program.

C. Administrative Organization of TBH

Tennessee Behavioral Health Inc. (TBH) is a wholly owned subsidiary of Magellan Behavioral Health, Inc., a subsidiary of Magellan Health Services, Inc. Prior to April

1, 1999, TBH was a wholly owned subsidiary of Preferred Health Partnership Companies, Inc. (PHP), a wholly owned subsidiary of Covenant Health. Effective August 1, 1998, TBH entered into an agreement with Merit Behavioral Care of Tennessee (MBCT) to perform all administrative, management, financial, and operational functions of TBH. MBCT was a wholly owned subsidiary of Merit Behavioral Care Corporation, which was wholly owned by Magellan Health Services, Inc. Effective October 1, 1998, MBCT assumed 100% of the risk associated with TBH's contract with the State of Tennessee Department of Mental Health and Mental Retardation to provide managed mental health and substance abuse services. TBH contracts with AdvoCare of Tennessee, Inc., a wholly owned subsidiary of Magellan, to manage the operations, administrative services and clinical services related to provision of all mental health benefits, to provide case management services and to arrange primary care and outpatient services. During the examination period, Green Springs Health Services, Inc., the direct parent of AdvoCare, has provided claims processing services.

The officers and directors for TBH as of June 30, 2000, were as follows:

Officers and Directors for TBH

C. Richard Orndoff	Charlotte Sanford
Andrew Cummings	Charles Klusener
Russell Petrella	James Bedenbaugh

D. Provider Contracts and Subcontracts

The contract between TDMHMR and TBH requires that TBH contract with the State of Tennessee's five regional mental health institutes. These institutes provide essential inpatient mental health services to the priority population. TBH has contracted with the regional mental health institutes on a per diem basis. Inpatient, intensive outpatient, and partial hospitalization services are also provided by hospitals across Tennessee on a per diem basis.

In addition, the contract encourages TBH to contract with community mental health centers (CMHCs). The primary providers of outpatient mental health services for the priority population are the CMHCs located across the state. TBH originally contracted with 29 CMHCs to provide medically/psychologically necessary designated covered services. The CMHCs act as care coordinators responsible for arranging the behavioral health care needs of their assigned participants. Compensation methods to CMHCs varied during the examination period based on the contractual arrangement negotiated between each CMHC and TBH. One contractual arrangement specified a certain per priority member per month rate to be used in the calculation of the monthly priority case rate paid to those centers. TBH calculates the monthly case rate for each of these centers by multiplying the number

of priority participants reported by a center by the specified per member per month rate, then dividing that number by the total priority cases reported for all centers. Other contractual arrangements specified a fixed case rate based on the total priority cases assigned to the CMHC. If the assigned members elect to receive services from other providers, then the CMHC's monthly case rate payments will be reduced on a percentage basis according to the services received.

On March 1, 2000, most CMHCs amended their contract with TBH to be reimbursed through a new compensation method. Instead of payments being based on the number of priority members assigned to the CMHC, the new compensation method reimburses the CMHC in tiered levels based on the average number of case management encounters per priority participants.

Each CMHC also receives grant payments at the same funding levels for the prior fiscal year based on TBH's percentage of total TennCare Partners enrollment. Grants represent payments for non-clinical adult services, psychosocial services, and crisis teams provided by the CMHCs.

Other providers include physicians, psychiatrists, licensed social workers, and hospitals and are paid based upon a fee schedule or per diem for the procedures or inpatient days provided.

Five TennCare managed care organizations (MCOs) have been contracted and paid by TBH a subcapitation based upon number of members enrolled in the MCOs. The MCOs have contracted with primary care physicians who provide a portion of the mental health services for TBH. Also, the MCOs provide some of the lab, transportation, and pharmacy services that are the responsibility of TBH.

Effective July 1, 1998, the State assumed financial responsibility for the cost of all behavioral health pharmacy services to TennCare enrollees in the TennCare Partners Program.

IV. PREVIOUS EXAMINATION FINDINGS

The following were deficiencies cited in the examination by the Comptroller of the Treasury, Division of State Audit, for the period January 1, 1997, through June 30, 1998.

1. Deficiencies in the Claims Processing

TBH did not fulfill contract reporting and processing efficiency requirements. Errors were discovered in the payment, denial, and copayment calculation of mental health and substance abuse claims. An explanation of benefits was not provided to uninsured members when a copayment calculation was required. TBH does not track outpatient mental health benefits for basic participants in order to perform reassessments.

2. Inaccurate Annual and Quarterly Statement Reporting
Equity was overstated $8,013,542 as of December 31, 1997, because of errors in the annual statement reporting. Equity was understated $659,660 as of June 30, 1998, because of errors in quarterly statement reporting.

3. Deficiencies in Encounter Data Reporting
TBH inadequately reported diagnosis codes as encounter data required by the contract.

4. Deficiencies in Provider Agreements
TBH did not include in the provider agreements all requirements specified by the TennCare Partners contract.

5. Deficiencies in Complaint and Appeals Procedures
TBH's documentation and resolution of participants' complaints and appeals were determined inadequate.

Finding 5 has been satisfactorily remedied. Findings 1, 2, 3, and 4 will be repeated in the current report.

V. SUMMARY OF DEFICIENCIES

A. Summary of Deficiencies – Financial

1. TBH did not provide the examiners with requested information, specifically the general ledgers of an affiliate, which support the allocation of administrative expenses on the NAIC Financial Statements.

2. TDCI non-admitted unsupported health care receivables of $707,718. This item resulted in TBH's June 30, 2000, net worth being overstated and adjusted by TDCI.

B. Summary of Deficiencies – Claims Processing System

1. TBH incorrectly paid three (3) of sixty (60) claims reviewed.

2. TBH improperly denied two (2) of sixty (60) claims reviewed.

3. Proper adjudication could not be determined for three (3) of sixty (60) claims.

4. Proper claims processing lags could not be ascertained for four (4) of sixty (60) claims reviewed.

5. TBH inadequately reported encounter data required by the TennCare Partners contract. The encounter data did not include all revenue, procedure, and diagnosis codes.

6. Of fifty (50) Regional Mental Health Institute claims reviewed, TBH incorrectly paid eighteen (18) claims.

7. Of fifty (50) Regional Mental Health Institute claims reviewed, TBH improperly denied twenty-six (26) claims.

8. Of fifty (50) Regional Mental Health Institute claims reviewed, two (2) claims did not contain all of the dates of service billed on the claim in TBH's claims processing system.

9. TBH is not in compliance with Tennessee Code Annotated (T.C.A.) §56-32-226(b), requirements for timely adjudication of claims.

C. Summary of Other Deficiencies

1. TBH did not include in the provider agreements all the requirements specified by the TennCare Partners contract Section 3.9.2.

2. TBH is non-compliant with Section 3.4.2.9 of the TennCare Partners contract regarding the explanation of benefits to participants.

VI. RESULTS OF TESTS CONDUCTED – FINANCIAL ANAYLSIS

A. Financial Analysis

As a BHO, TBH files annual and quarterly statements with the Tennessee Department of Commerce and Insurance. The department uses the information filed on these reports to determine if the behavioral health organization meets the minimum requirements for statutory reserves. The statements are filed on a statutory basis of accounting. Statutory accounting differs from generally accepted accounting principles because "admitted" assets must be easily converted to cash to pay for outstanding claims. "Non-admitted" assets such as furniture, equipment, and prepaid expenses are not to be included in the determination of plan assets and should be reduced from equity.

As of December 31, 1998, TBH reported $25,160,333 in admitted assets, $17,866,123 in liabilities and $7,294,210 in equity on its annual statement. TBH reported total revenues of $137,185,454 and total expenses of $147,398,027, producing a net income/(loss) of ($10,212,573) for the period January 1 through December 31, 1998. Revenue is composed of $136,730,611 in capitation payments from the TennCare Partners Program, $344,682 in investment income, and $110,161 in miscellaneous income. The plan reported $128,023,947 in mental health and substance abuse services

and $19,374,080 in administrative expenses. Premium taxes paid to the State were reported as $2,437,136. Mental health and substance abuse services represent 94% of capitation payments from TennCare, and administrative expenses less premium taxes represent 12.4% of capitation fee payments from TennCare. TBH reported a restricted deposit of $1,000,000 to satisfy requirements of the TennCare Partners Program contract.

As of December 31, 1999, TBH reported $16,581,385 in admitted assets, $13,975,173 in liabilities and $2,606,212 in equity on its annual statement. TBH reported total revenues of $126,250,262 and total expenses of $129,197,103, producing a net income/(loss) of ($2,946,841) for the period January 1 through December 31, 1999. Revenue is composed of $125,431,378 in capitation payments from the TennCare Partners Program, $518,884 in investment income, and $300,000 in other health care related income. The plan reported $111,461,520 in mental health and substance abuse services and $17,735,583 in administrative expenses. Premium taxes paid to the State were reported as $2,423,464. Mental health and substance abuse services represent 89% of capitation payments from TennCare, and administrative expenses less premium taxes represent 12.2% of capitation payments from TennCare. TBH reported a restricted deposit of $3,200,000 to satisfy requirements of the TennCare Partners Program contract and an increased requirement imposed by TDCI for failure to provide required financial information.

As of June 30, 2000, TBH reported $19,626,739 in admitted assets, $15,183,981 in liabilities and $4,442,758 in equity on its quarterly statement. TBH reported total revenues of $65,122,791 and total expenses of $64,519,254, producing a net income of $603,537 for the period January 1 through June 30, 2000. Revenue is composed of $64,688,688 in capitation payments from the TennCare Partners Program and $434,103 in investment income. The plan reported $55,378,037 in mental health and substance abuse services and $9,141,217 in administrative expenses. Premium taxes paid to the State were reported as $1,136,830. TennCare capitation payments per the TennCare Bureau were $64,977,443. The difference between the Bureau reported amount and TBH reported of $288,745 is due to TBH's timing of revenue recognition related to Amendment 2 to the Partners contract; TBH correctly non-admitted this receivable from the State of Tennessee. Mental health and substance abuse services represent 85% of capitation fee payments from TennCare, and administrative expenses less premium taxes represent 12.4% of capitation fee payments from TennCare.

During the examination, TDCI reviewed account balances on the NAIC Quarterly and Annual Statements to determine if they were properly supported. Examiners also reviewed subsequent events to determine if significant changes in accounting estimates were necessary.

The TennCare Partners contract imposes certain financial requirements on the BHOs regarding minimum net worth, working capital and restricted deposits.

1. Net Worth

As of June 30, 2000, the TennCare Partners contract required TBH to establish and maintain a minimum net worth equal to the greater of (1) three million dollars ($3,000,000), or (2) an amount totaling five percent (5%) of the first one hundred fifty million dollars ($150,000,000) of the TennCare revenue earned by TBH under the TennCare Partners contract for the prior calendar year, plus three percent (3%) of the TennCare revenue earned by the TBH under the TennCare Partners contract in excess of one hundred fifty million dollars ($150,000,000) for the prior calendar year. This net worth was to be determined by statutory accounting principles utilized by TDCI in regulating HMOs licensed in the State of Tennessee. Based on this minimum net worth calculation, TBH was required to maintain a minimum net worth of $6,271,569 during the calendar year 2000 ($125,431,378 TennCare revenue calendar year 1999 multiplied by 5%). However, effective July 1, 2000, the Contract was amended to implement a change in the net worth requirement based upon the statutory requirements set out in TCA 56-51-136. The new requirement is the same as for TennCare Health Maintenance Organizations or 4% of the first $150,000,000 in TennCare premium revenue on the most recent annual statement filed plus 1.5% of the annual premium revenue in excess of $150,000,000.

TBH contends that during 2000, it was determined, based on a detail review of claims payments, that there were claims that had been paid inappropriately to providers. The reasons for the payments being inappropriate varied (i.e. non-covered services, contract non-compliance, claims not filed in a timely manner, etc.) While the BHOs worked on recovering the money, a receivable of $707,718 was booked by the BHO. TDCI requested support for the receivable and none was provided. That receivable has been determined unsupported and will be adjusted from net worth.

TBH reported net worth at June 30, 2000 of $4,442,758; net worth adjusted for the unsupported health care receivable of $707,718 resulted in adjusted net worth of $3,735,040. TBH's minimum net worth requirement calculated under the TennCare Partners Contract is $6,271,569 at June 30, 2000. TBH's adjusted net worth is $3,735,040, for a statutory net worth deficiency of $2,536,529 at June 30, 2000.

In April 2000 TDCI became aware that TBH had a net worth deficiency of $2,812,914 as of December 31, 1999. TDCI required TBH to submit monthly financial statement projections from April 1, 2000, through December 31, 2000, and actual financial performance reports beginning in May 2000 and continuing forward until TBH met its statutory net worth requirement in order to monitor TBH's financial condition and progress in correcting the net worth deficiency. Using the new net worth calculation TDCI determined that the deficiency was corrected by September 30, 2000, prior to the beginning of fieldwork for this examination. TBH would continue to be in a positive net worth position at September 30, 2000, after the adjustment to the receivable mentioned above.

TDCI is aware that there is currently a payment dispute between TBH and TDMHMR regarding payments to the Regional Mental Health Institutes. To date TDCI has not received requests for independent review from TDMHMR for the disputed claims. If the potential liability comes to pass, TBH could be in a negative net worth position at June 30, 2000, depending on settlement amounts. TDCI will continue to closely monitor the progress of the dispute resolution.

2. Working Capital

TBH must establish and maintain a positive working capital defined as current assets greater than current liabilities per Section 3.3.2.2 of the TennCare Partners contract. TBH's current assets did exceed current liabilities at June 30, 2000.

3. Restricted Deposit

TBH maintained a restricted deposit of $3,200,000 at June 30, 2000, to satisfy requirements of Section 3.3.2.3 of the TennCare Partners Program contract.

4. Contractor's Management Fee

Per Section 3.15.3 of the TennCare Partners Program contract the BHO is allowed to retain ten percent (10%) of the capitation payment for administrative and management fees and profits with the remaining being made available for providing or arranging direct mental health and substance abuse services to TennCare enrollees. No later than July 15 of each calendar year, the BHO must calculate the total amount of expense for covered services incurred during the preceding calendar year, as well as any premium taxes paid by the BHO to the state. If the actual accrued amount paid by the BHO for covered services and premium taxes is less than the required amount paid the BHO by the state for the preceding year, the BHO must remit to TDMHMR one hundred percent of the difference. However, the amount to be remitted by the BHO shall be reduced by any cumulative losses incurred by the BHO from the participation in the TennCare Partner's Program in prior years. Note: Amendment 3 to the Partner's contract effective July 1, 2000, no longer allows for a cumulative loss carry forward.

As of December 31, 1999, TBH's cumulative losses based on the above calculations totaled $10,020,277.

B. Allocation of Administration Expense

As previously discussed, AdvoCare, a related party, contracts with TBH to manage the operations, administrative services and clinical services related to provision of all mental health benefits, to provide case management services and to arrange primary care and outpatient services. TBH did not provide the examiners with requested information, specifically the general ledgers/trial balance of its affiliate, AdvoCare, which support the

allocation of administrative expenses on the NAIC Financial Statements. TBH's failure to provide the requested information is a violation of the following TennCare Partners contract terms and Tennessee Code Annotated Statutes:

Section 3.14.2 of the TennCare Partners contract between the plan and the state specifies:

> The CONTRACTOR shall maintain books, records, documents, and other evidence pertaining to the administrative costs and expenses incurred under this CONTRACT… These records, books, documents, etc., shall be available for review by authorized federal, State, and Comptroller personnel…

Section 3.14.3 of the TennCare Partners contract specifies:

> The CONTRACTOR shall make available to the Tennessee Department of Mental Health and Mental Retardation or its representatives and other state and federal personnel…all records, books, documents, and other evidence pertaining to this CONTRACT, as well as appropriate administrative and /or management personnel who administer the plan.

T.C.A. § 56-51-154, Applicability of provision of title 56, chapter 32 to successor organizations, states:

> Provisions of title 56, chapter 32 which are specifically applicable to health maintenance organizations which participate in the TennCare Program under the Social Security Act, title XIX, or any successor to the TennCare program shall also be applicable to prepaid limited health service organizations which participate in the TennCare program or any successor program.

T.C.A. § 56-32-232, Investigatory powers of the department of commerce and insurance, states:

> For the purpose of regulation and oversight of health maintenance organizations that participate in the TennCare program under the Social Security Act, Title XIX, or any successor to the TennCare program, and in addition to the powers and duties set forth in this title, the department of commerce and insurance has the power to examine and investigate the affairs of every person, entity, health maintenance organization, an affiliate of the parent of the health maintenance organization, or an affiliate of the health maintenance organization, in order to determine whether the person, entity, health maintenance organization, an affiliate of the parent of the health maintenance organization, or any affiliate of the health maintenance organization, is operating in accordance with the provisions of this part and title 71, chapter 5.

Management's Comments:

Management did not respond.

VII. RESULTS OF TESTS CONDUCTED – CLAIMS PROCESSING SYSTEM

A. Sixty (60) claims were judgmentally selected from a file containing the claims history of two hundred (200) TBH members. The claims reviewed were for services provided from July 1, 1998 through June 30, 2000. Of the sixty (60) claims tested, forty-five (45) were paid and fifteen (15) were denied.

1. Adjudication Accuracy

The purpose of adjudication accuracy testing is to determine whether the decision to reject, deny or pay a claim was appropriate based on available information including but not limited to eligibility status, claim submission date, date of services and denial reasons.

a. Paid Claims

Forty-two (42) of the forty-five (45) paid claims tested were correctly paid and three (3) were incorrectly paid. The errors noted in the three (3) incorrectly paid claims are listed below:

- One (1) claim did not pay in agreement with the negotiated rate. According to the fee schedule provided, payment should have been for 60% of billed charges; instead, this claim paid one line item at 100% of billed charges. (990075804)

- One (1) inpatient claim paid six (6) of the seven (7) days that should have been paid. The first day denied incorrectly for no coverage in effect when both the TennCare system and the TBH claims processing system show the enrollee eligible beginning at the first date of service. (990440321)

- One (1) claim initially processed correctly. However, upon review of the claim's history, the claim was later paid twice. The claim should have only been paid once. (20000172312)

Of the forty-five (45) paid claims tested, adjudication accuracy could not be verified for two (2) of the claims:

- For one (1) claim the paper claim was not supplied by TBH. (980239552)

- For one (1) claim the paper claim supplied by TBH was illegible. (990104171)

Of the forty-five (45) paid claims tested, proper claims processing lags could not be ascertained for four (4) claims:

- For one (1) claim, there was not a date-received stamp. (990078023)

- For three (3) claims, the date-received stamp on the paper claim was not legible. (990104171, 990277081, 990461796)

Management's Comments:

Management did not respond.

b. Denied Claims

Thirteen (13) of the fifteen (15) denied claims were appropriately denied and two (2) were improperly denied. The errors noted in the two (2) improperly denied claims are listed below:

- One (1) claim was denied for no coverage in effect. The TennCare system and the TBH claims processing system show the enrollee eligible at the date of service. (980187992)

- One (1) claim was denied for timely filing limitation when it was resubmitted by the provider. The claim was initially sent back to the provider for correction. The provider then returned the corrected claim within the 60 days provided by TBH for resubmission; therefore, the claim should not have been denied for untimely filing. (20000217245)

Of the fifteen (15) denied claims tested, adjudication accuracy could not be verified for one (1) of the claims because the paper claim was not supplied by TBH. (990044616)

Management's Comments:

Management did not respond.

2. Price Accuracy Testing

The purpose of price accuracy testing is to determine whether payments allowed for specific procedures are in accordance with the system price rules assigned to providers, whether payments are in accordance with provider contracts, and whether amounts were calculated correctly.

All forty-five (45) paid claims were tested and forty-four (44) were priced accurately according to the executed provider contracts. One (1) claim was incorrectly priced and paid one line item at 100% of billed charges rather than 60% of billed charges as dictated in the provider contract.

Management's Comments:

Management did not respond.

3. Remittance Advice Testing

Remittance advices are used to communicate to the providers relevant information regarding the payment or denial of their claims. Remittance advices were requested for five (5) of the sixty (60) tested claims to compare the payment and/or denial reasons per the claims processing system to the information communicated to the providers.

No differences were noted between the claims payment and/or denial information per the claims processing system and the related information communicated to the providers on the five (5) remittance advices reviewed.

4. Electronic Claims Capability

During the examination period, TBH had the ability to receive and process claims electronically filed by transportation providers and the community mental health centers. Of the sixty (60) claims tested, twenty-three (23) were filed electronically.

Management's Comments:

Management did not respond.

5. Comparison of Actual Claim With System Claim

Original hard copy claims were requested for the thirty-seven (37) claims of the sixty (60) tested that were not filed electronically by the providers. (Refer to Section VII.A.4. above.) The information reported on the hard copy claims was compared to the claims information entered into the claims processing system. Of the thirty-seven (37) claims reviewed, eleven (11) contained data elements that did not match the data elements entered into the claims processing system. Of the eleven (11) claims with discrepancies, six (6) of the claims are mentioned in more than one category resulting in a total of seventeen (17) discrepancies noted below:

- For five (5) claims, a substitute code was incorrectly reported for the medical diagnosis codes indicated on the claims. (990104171, 990239036, 990046339, 20000226288, 990277081)

- For one (1) claim, the reported revenue code per the claim was not the same as the revenue code entered into the claims processing system. (990396892)

- For one (1) claim, different dates of service were recorded in claims processing system than those on the claim. (990188918)

- For one (1) claim , the number of units entered into the claims processing system did not agree with the number reported on the claim. (990337997)

- For nine (9) claims, all listed diagnosis codes were not reported as encounter data. The list of required encounter data elements includes up to five (5) diagnosis codes. (990396892, 990440321, 990295544, 990239036, 990046339, 20000226288, 980187992, 990277081, 990337997)

For the twenty-three (23) electronically filed claims, there is not a method of verifying the information in TBH's claims processing system for accuracy. However, it was noted that for two electronically filed claims a substitute code was incorrectly reported for the medical diagnosis codes indicated on the claims. (03JXVU7Z3YEN2VO, 00MGG8SN06NQJ5J)

Management's Comments:

Management did not respond.

B. Fifty (50) Regional Mental Health Institute (RMHI) claims for services provided from July 1, 1998 through September 30, 2000 were reviewed. The claims were selected for review based on a complaint that they were processed incorrectly. Of the RMHI claims tested, nineteen (19) were paid and thirty-one (31) were denied. The results of the claims testing are summarized below:

1. Paid Claims

Eighteen (18) of the nineteen (19) paid claims were paid incorrectly. *Three (3) of these claims were initially paid incorrectly but were later reprocessed and correctly paid.* Of the (18) incorrectly paid claims, three (3) of the claims are mentioned in more than one category resulting in a total of twenty-one (21) deficiencies listed below:

- Four (4) claims did not pay in agreement with the negotiated rate. (20000217408, 20000261119, 20000432822, 20000550682)

- Six (6) claims did not pay all of the inpatient days billed denying some dates of service for no coverage in effect for the enrollee. In each instance the enrollee had coverage from the initial date of service throughout the stay. Three (3) of these claims were continued stays and therefore both the admission date and the last day on the interim billing should have been paid. (990028977, 980278713, 990126914, 990237478, 20000435738, 980278638)

- Seven (7) claims did not pay all of the inpatient days that were pre-authorized per the authorization letters sent to the RMHIs. *Two (2) claims were later reprocessed and the remaining authorized days were paid.* (980278262, 990030867, 990174236, 980179717, 990172505, 9900631021, 20000554490)

- One (1) claim paid one date of service and denied the other for "no pre-authorization on file". The enrollee was presumptively assigned to Premier and the pre-authorization letter was issued by AdvoCare for Premier. The enrollee was later assigned to TBH and the authorization was moved to TBH. *The claim was later reprocessed and paid the other date of service.* (990226284)

- Three (3) claims only paid one (1) date of service each for court-ordered emergency admissions. For each claim the second denied date of service should have been paid. TBH is required to pay at least the first 72 hours for a court-ordered emergency admission per Section 2.6.5.1.1.1 of the TennCare Partners contract. (980278713, 990030867, 980278638)

Management's Comments:

Management did not respond.

2. Denied Claims

Five (5) of the thirty-one (31) denied claims were appropriately denied and twenty-six (26) were improperly denied. *Nine (9) of the improperly denied claims were later reprocessed and paid.* Of the twenty-six (26) improperly denied claims, six (6) of the claims are mentioned in more than one category resulting in a total of thirty-two (32) deficiencies listed below:

- Six (6) claims denied for no coverage in effect for the enrollee. In each instance the enrollee had coverage from the initial date of service throughout the stay but the entire claim was denied. (990114602, 990102027, 990028967, 990028799, 990044917, 990044921)

- Six (6) claims denied for "no pre-authorization on file" and/or "dates of service beyond the authorization period". In each instance a pre-authorization from AdvoCare was issued to the RMHI. *Two (2) of the claims were later reprocessed and paid.* (980141193, 990114672, 990174271, 990098860, 990063186, 20000655820)

- Six (6) claims denied for "no pre-authorization on file". AdvoCare issued each of these pre-authorization letters for Premier. Two (2) of the enrollees were presumptively assigned to Premier and were later assigned to TBH. *The authorizations for three (3) of the claims were later moved to TBH and were then*

reprocessed and paid. (980219808, 980219795, 990050216, 990110068, 20000618974, 20000297892)

- Five (5) claims denied for "coordination of benefits" (COB). Four (4) of these claims were for Medicare dual-eligible enrollees. However, the claims were correctly submitted for payment showing the Medicare benefits had been exhausted and the days were non-covered Medicare days. Per TBH, this information is sufficient for paying the claims. *One (1) of these claims was later reprocessed and paid.* (20000655423, 20000360846, 20000361180, 20000355580) One (1) claim was for an enrollee with other insurance. No other insurance was indicated on the claim. The enrollee's other insurance had expired before the date of service on the claim. (20000355577)

- Two (2) claims denied for "services covered by Medicare". These claims were for Medicare dual-eligible enrollees. However, the claims were correctly submitted for payment showing the Medicare benefits had been exhausted and the days were non-covered Medicare days. *One (1) claim was later reprocessed and paid.* (20000655349, 20000131259)

- One (1) claim denied without a denial code or explanation communicated to the provider on the provider remittance advice. The dates of service were pre-authorized. (20000217290)

- Five (5) claims denied when the services were court-ordered emergency admissions. TBH is required to pay at least the first 72 hours for a court-ordered emergency admission per Section 2.6.5.1.1.1 of the TennCare Partners contract. *Two (2) of these claims were later reprocessed and paid.* (990044917, 980141193, 980219808, 990050216, 20000355577)

- One (1) claim denied for "ineligible diagnosis". However, the wrong diagnosis code was incorrectly entered into TBH's claims processing system. (990102027)

Of the thirty-one (31) denied claims tested, two (2) of the claims did not contain all of the dates of service billed on the claim in TBH's claims processing system. (200003611801, 200003555801)

Management's Comments:

Management did not respond.

C. Results of Prompt Pay Analysis

As part of our on-going analysis of the BHOs, TDCI requests on a quarterly basis a data file from the BHO containing all claims processed for a selected month. The data file is used to determine the BHO's compliance with the processing

requirements defined in T.C.A. §§ 56-32-226(b) and 71-5-2314 which requires that each BHO (as an entity contracting with the state in the TennCare Partners Program) shall ensure that 90% of claims for payments of services delivered to a TennCare Partners Program enrollee are paid within 30 days of the receipt of such claims and shall process, and if appropriate pay, within 60 days 99.5% of all provider claims. Process means the BHO must send the provider a written remittance advice or other appropriate written notice evidencing that the claim has been partially or totally denied and specify all known reasons for denial.

Results of the Data File Analyses

Claim Type	Within 30 days	Within 60 days	Greater than 60 days
January 2001			
Fee For Service Claims Only	58.3%	99.3%	.7%
Fee For Service and CMHC Claims	76.6%	99.6%	.4%
April 2001			
Fee for Service Only	73.09%	99.56%	.44%
Fee For Service and CMHC Claims	87.92%	99.80%	.20%
May 2001			
Fee for Service Only	54.57%	99.10%	.90%
Fee For Service and CMHC Claims	72.46%	99.45%	.55%
June 2001			
Fee for Service Only	65.74%	99.20%	.80%
Fee For Service and CMHC Claims	78.30%	99.49%	.51%
T.C.A. Requirement	90%	99.5%	.5%

The results are presented in both formats because of the unique contracting arrangement with the CMHCs. The BHO makes interim payments for the current month claims based on a reconciliation of claims submitted for dates of service six months in the past. CMHC claims submitted on the data file have been considered paid within 30 days for this analysis.

TBH is not in compliance with the T.C.A. §§ 56-32-226(b) and 71-5-2314 requirements that 90% of claims are paid with 30 days of receipt. TBH is in compliance with §§ 56-32-226(b) and 71-5-2314 requirements to process within 60 days 99.5% of all provider claims only if CMHC claims are also considered in the analysis.

Management's Comments:

Management did not respond.

VIII. REPORT OF OTHER FINDINGS AND ANALYSES

A. Provider Contract Language Deficiencies

The TBH provider agreements did not contain all requirements specified in Section 3.9.2 of the TennCare Partners contract.

Four executed provider agreements were requested for compliance analysis; one CMHC agreement, one primary care physician (PCP) agreement, one hospital agreement and one transportation agreement. Of the four agreements requested, only three were provided. (See item B. below.)

Language describing the following requirement is excluded or deficient from the CMHC contract:

> Section 3.9.2.30. Specify that both parties recognize that in the event of termination of this Contract between the CONTRACTOR and TDMHMR for any of the reasons described in Section 5.1. of this Contract, the provider contract shall terminate immediately and provider shall immediately make available, to TDMHMR, or its designated representative, in a usable form, any or all records, whether medical or financial, related to the provider's activities undertaken pursuant to the BHO/provider contract. The provision of such records shall be at no expense to TDMHMR

Language describing the following requirement is excluded or deficient from both the PCP and CMHC contract:

> Section 3.9.2.33. State that the provider shall not receive more than one hundred five percent (105%) of the rate negotiated between the CONTRACTOR and provider as the final payment, so that any incentive or bonus paid the provider by the CONTRACTOR shall not exceed five percent (5%) of the rate negotiated between the CONTRACTOR and the provider. The provider contract shall specify that the provider shall be liable for a portion of any excess benefit costs associated with the provision of services pursuant to the provider contract and shall describe the methodology to be used in the allocation of such excess benefit costs. The provider contract shall also specify that the provider shall not be required to absorb any amount of the CONTRACTOR's excess administrative and/or management fees.

Language describing the following requirement is excluded or deficient from the PCP contract:

> Section 3.9.2.34. Specify that the provider shall be required to accept TennCare reimbursement amounts for services provided under the Contract between the provider and CONTRACTOR to TDMHMR Partners Program

> Participants and shall not be required to accept TennCare reimbursement amounts for services provided to persons who are covered under another health plan operated or administered by the CONTRACTOR;

Language describing the following requirement is excluded or deficient from all three provider contracts reviewed:

> Section 3.9.2.40. Specify the provider submit to the CONTRACTOR the necessary information so that the CONTRACTOR can determine the average unit costs pursuant to Section 3.12.7.4.

Language describing the following requirement is excluded or deficient from both the CMHC and hospital contracts:

> Section 3.9.2.44. No agreement executed between the CONTRACTOR and a provider shall require the provider to assume financial risk for the provision of services which are not directly or indirectly furnished by that provider to a participant in the TennCare Partners Program. The term indirectly means that the provider retains ultimate management and control over the services furnished to participants in the TennCare Partners Program. The CONTRACTOR may request the TennCare Division of TDCI to provide, in advance, a written opinion whether a proposed contract provision is in compliance with this section, and the TennCare Division of TDCI must respond to any such request within thirty (30) calendar days after receipt of the request by the TennCare Division of TDCI. TDMHMR, in addition to any and all remedies set forth in the CONTRACT, may also commence an action against the CONTRACTOR in accordance with Section 6.11 of the CONTRACT to recover from the CONTRACTOR any losses incurred by a provider as a result of the CONTRACTOR's breach of this section. Any amounts recovered by TDMHMR which are for losses incurred by a provider as a result of the CONTRACTOR's breach of this section shall be returned without interest to the provider.

Management's Comments:

Management did not respond.

B. Transportation Contracts

One of the four contracts requested from TBH for testing was a transportation contract. TBH provided a memorandum of agreement with the transportation provider that was conditional until the parties executed a contract. None of the transportation provider contracts were executed at the time of our review. (Note:

telephone follow-up indicated that currently the majority of the transportation contracts have been executed.)

Management's Comments:

Management did not respond.

The examiners hereby acknowledge the courtesy and cooperation of the officers and employees of TBH.